AUTHORIZATION FOR TREATMENT

AND

DISCLOSURE OF CLINICAL INFORMATION

I am legally responsible for ____ and hereby give consent for any medical, dental, counseling, therapy, or drug/alcohol abuse treatment, and/or drug testing that becomes necessary while my child is in school. I also approve such inoculations and treatments in the field of preventive medicine as may be deemed necessary by medical personnel.

I further understand that I will be notified when emergency situations arise in medical, dental, counseling, and substance abuse or drug/alcohol treatment situations.

Consent is also given for the disclosure and exchange of pertinent information essential for medical treatment, drug/alcohol treatment, substance abuse screening or counseling services. This information may be interchanged between the Health Services, Behavioral and Mental Health Services and Creek Nation Eufaula Dormitory staff beginning August 8, 2006 and ending May 18, 2007.

Signature of Parent/Guardian:____

Relationship:____Phone:________________

Address:____
Street City State Zip

Date:_________________________